State Employee Group Dental Program

State Health Benefits Program

ELIGIBILITY

The State Employee Group Dental Program is available to full-time State employees and their eligible dependents. New employees, may enroll by completing a *NJ State Dental Benefits Application* during the first sixty days of employment. The application is available from your Human Resources representative. If you do not enroll when first eligible, you have the option to enroll each year during the annual SHBP Open Enrollment Period. Open Enrollment is normally held in the fall, with coverage effective the following January. If you do not enroll because of other dental coverage and you lose that coverage, you can be enrolled within 60 days of the loss of coverage.

Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans or drop coverage. In addition, no employee or dependent can be covered under more than one State dental plan.

WHAT ARE MY DENTAL PLAN CHOICES?

You have a choice between two types of dental plans:

- The Dental Expense Plan; or
- A Dental Plan Organization (DPO).

Dental Expense Plan

The Dental Expense Plan is a traditional indemnity-type plan administered by Aetna Dental. The plan allows you to choose any licensed dentist for your dental care. There is a deductible to satisfy for some services and some services are eligible only up to a limited amount. The annual plan deductible is $50 per person; $150 per family. The deductible does not apply to diagnostic, preventive, and orthodontic services. After you satisfy the annual deductible you are reimbursed a percentage of the reasonable and customary charges for services that are covered under the plan.

The Dental Expense Plan provides for the following benefits:

- Diagnostic and Preventive services are paid at 100% of reasonable and customary allowances with no deductible.
- Basic Services such as fillings and extractions, are paid at 80% of reasonable and customary allowances after deductible.
- Major Restorative services, such as crowns, are paid at 65% of reasonable and customary allowances after deductible.
- Prosthodontic services for new or replacement dentures are covered at 50% of reasonable and customary allowances after deductible. Repairs to existing dentures are covered at 80% of reasonable and customary allowances after deductible.
- Periodontics (treatment of gum disease) is covered at 50% of reasonable and customary allowances after deductible.
- Orthodontics are available after you have been employed for 10 months, (with no deductible), but only for your children under the age of 19. Orthodontic services are reimbursed at 50% of reasonable and customary allowances and have a separate $1,000 lifetime reimbursement benefit maximum.
- Benefit Maximum per covered individual is $3,000 annually. This maximum applies to all eligible services except orthodontic, which has a separate $1,000 lifetime benefit maximum.

With the exception of emergency care, it is strongly recommended that you ask your dentist to obtain approval in advance from Aetna if the proposed service includes charges above $300, or if the service includes charges for crowns, inlays, onlays, periodontics, prosthodontics, or orthodontics regardless of cost. With advance approval you will know what services are covered and what payments will be made.

Dental Expense Plan members can take advantage of a special Aetna network of participating dental providers. In this network, participating dental providers contract with Aetna for a discounted fee schedule. When you use a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the participating dental provider will submit the claims directly to Aetna, eliminating the necessity of your filing claim forms. To find out if your provider participates in the discounted network, call Aetna at 1-877-238-6200.

Dental Plan Organizations

The Dental Plan Organizations (DPOs) are companies that contract with a network of providers for dental services. There are several DPOs to choose from in the State Group Dental Program. A list of participating DPOs is available from your Human Resources representative or from the Division of Pensions and Benefits (see For More Information below).

You must use providers participating with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the State program since DPOs also service other organizations.

When you use a DPO dentist, diagnostic and preventive services are covered in full. Most other eligible expenses require a copayment (see chart on page 3). In addition, orthodontic treatment is covered for both children and adults, subject to a copayment. If your dentist drops out of the DPO, you must select another dentist from the DPO. If there are none available within 30 miles of your home, or if you move and your DPO cannot provide a dentist within 30 miles of your home, you may switch plans immediately.

HOW MUCH OF THE PREMIUM COST DO I PAY?

The premium cost for dental plan coverage is shared between the State and the employee. The amount of your payroll deduction is available from your Human Resources representative. Employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan of the State's IRC Section 125 program, Tax$ave. Participation in the Premium Option Plan is automatic unless you file a form declining participation. See Fact Sheet #44, *Tax$ave,* for more information about this program.

WHICH PLAN IS BEST FOR ME?

Your choice of a dental plan is a personal decision. You can use the summary chart attached to this fact sheet to compare benefit levels under each type of plan. In deciding whether to enroll and which plan to choose, you should consider:

- The nature and amount of your anticipated dental expenses for the next year;
- The covered services provided by the Dental Expense Plan or a DPO;
- The differences in out-of-pocket costs for each type of plan; and
- The degree of flexibility that you may want in selecting a dentist.

If you choose a DPO, you must select a dentist who participates with that particular DPO and who can accept you and your family as patients.

FOR MORE INFORMATION

For more information on the State Employee Group Dental Program or the names and phone numbers for the individual dental plans, see the *State Employee Group Dental Program Member Handbook*, available from your Human Resources representative, by contacting the Division of Pensions and Benefits, or over the Internet at: *www.state.nj.us/treasury/pensions/shbp.htm*.

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PLAN COMPARISON — The following chart provides a summary description of a variety of dental services under the two types of dental plans offered by the State Employee Group Dental Program. The chart is not complete and does not describe all the benefits, limitations, or conditions associated with coverage under either type of plan. Please refer to the *State Employee Group Dental Program Handbook* for additional details.

	Dental Expense Plan	**Dental Plan Organization (DPOs)**
Deductible	$50 per person per calendar year. None for diagnostic/preventative and orthodonic services. Maximum of 3 individual deductibles ($150) per family.	None.
Coinsurance	Plan pays: 100% Diagnostic and Preventative 80% Basic Restorative[1]. 65% Major Restorative[1]. 50% Periodontic, Prosthodontics[1].	Plan pays 100% (less copay). 100% Diagnostic and Preventative.
Copayments	None.	Varies depending on service.
Benefits Maximum	$3000 per member annually (excluding orthodontics). $1,000 (lifetime) per child for orthodontics.	Unlimited.
Provider Limitations	Any licensed dentist.	Must use DPO participating dentist.
Selected Services	**Some services listed below may be covered subject to deductibles and coinsurance as shown above.**	**Services listed below are covered in full subject to copayments as shown below.**
Examinations	Up to 2 exams (oral evaluations) are covered each calendar year. Plan pays 100%.	One exam per 6 month interval. Plan pays 100%.
X-rays	Covered subject to limitations. Plan pays 100%.	Covered subject to limitations. Plan pays 100%.
Cleanings	Up to 2 cleanings (oral prophlylaxis) covered each calendar year. Plan pays 100%.	One cleaning per 6 month interval. Plan pays 100%.
Fluoride applications	Covered only for children under age 19. Plan pays 100%[1].	Covered. Plan pays 100%.
Tooth sealants	Covered for children under age 19 (with restrictions). Plan pays 100%[1].	Covered only for children under age 19. No copayment (limitations apply).
Routine fillings	Plan pays 80%[1].	Covered. Copayments may apply[2].
Simple extraction	Plan pays 80%[1].	Covered after copayment of $20.
Crowns	Plan pays 65%[1].	Covered after copayment of $155 - $225[2].
Root Canal (Endodontics)	Plan pays 80%[1].	Endodontic Therapy covered after copayment of: $100 - $175[2].
Dentures	Repair of existing dentures covered at 80%[1]. New or replacement dentures covered at 50%.	Covered after copayment (with limitations)[2].
Oral surgery for removal of impacted tooth	Plan pays 80%.	Covered after copayment of $65.
Periodontics	Plan pays 50% (with limitations).	Covered after copayment of: $30 for gingivectomy (per tooth). $55 for root planing (per quadrant). $175 for osseous surgery.
Orthodontic	After you have been employed for 10 months, eligible services covered at a 50% coinsurance level, up to a $1000 lifetime maximum. Covered only for those who start treatment before age 19. (See page 18 of the *State Employee Dental Program Handbook* for specifics.)	Maximum treatment is 24 months. Copayment as follows: Patient under age 18: • after copayment of $1,000 or 50% of bill whichever is less. Patient age 18 or over: • after copayment of $1,750 or 50% of bill whichever is less.

[1]You are responsible for the amount the dentist charges above the reasonable and customary allowances.

[2]See pages 21-29 of the State Employee Group Dental Program Handbook.